

**STATE OF KANSAS  
SHARED LEAVE PROGRAM**

Shared Leave Donation Form

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**PART I - To be completed by employee.**


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Name: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

Agency Name/Department Number: \_\_\_\_\_

Work Address: \_\_\_\_\_

(City)

(State)

(Zip)

Work Phone: \_\_\_\_\_

Donations must be made in full-hour increments. **Unless the donating employee is separating from state service**, the vacation leave balance must be at least 80 hours and the sick leave balance must be at least 480 hours after the donation is made.

Please indicate the type and amount of leave to be donated:

Vacation Leave Hours: # hours donated \_\_\_\_\_ to:

(Name)

(Employee ID #)

(Agency)

Sick Leave Hours: # hours donated \_\_\_\_\_ to:

(Name)

(Employee ID #)

(Agency)

I understand that my donation is voluntary and confidential. I understand that my leave balance will be decreased by the amount contributed. I understand this donation may affect the payout of sick leave upon retirement or the payout of vacation leave upon any termination.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

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**PART II - To be completed by the agency personnel office.**


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Will the above-named employee's vacation leave balance be below 80 hours if the above-mentioned number of vacation leave hours are donated? Yes \_\_\_\_\_ No \_\_\_\_\_

Will the above-named employee's sick leave balance be below 480 hours if the above-mentioned number of sick leave hours are donated? Yes \_\_\_\_\_ No \_\_\_\_\_

**If the employee is donating at the time of separation from state service, please disregard the questions above and indicate with an X in the space provided.**

The donating employee's current salary is: \_\_\_\_\_

Is the donating employee terminating? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, retiring or resigning? \_\_\_\_\_

Appointing Authority or Designee Signature  
DA 223 (06/03)

Date \_\_\_\_\_

**Shared Leave Donation Form**

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**Part III - To be completed by the appointing authority.**

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I hereby approve \_\_\_\_\_ deny \_\_\_\_\_ donation of leave for the above-named employee.

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Appointing Authority or Designee Signature

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Date

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**PART IV - To be completed by the Division of Personnel Services.**

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The above-named employee's vacation leave balance has been reduced by \_\_\_\_\_ hours.

The above-named employee's sick leave balance has been reduced by \_\_\_\_\_ hours.

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Appointing Authority or Designee Signature

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Date

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**PART V - To be completed by the Division of Personnel Services.**

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(Receiving employee)

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Department Number

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Employee ID#

has been credited with \_\_\_\_\_ hours of shared leave.

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Appointing Authority or Designee Signature

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Date

Original to the Division of Personnel Services. Copies to the receiving employee's agency and the donating employee.